

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0039768</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																		
Facility Name: <u>Lexington of Lake Zurich</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																		
Address: <u>930 South Rand Road</u> <u>Lake Zurich</u> <u>60047</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																		
County: <u>Lake</u>																				
Telephone Number: <u>(847) 726-1200</u> Fax # <u>(847) 726-1265</u>																				
IDPA ID Number: <u>363748801001</u>																				
Date of Initial License for Current Owners: <u>08/20/94</u>																				
Type of Ownership:																				
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		<input checked="" type="checkbox"/> PROPRIETARY																		
<input type="checkbox"/> Charitable Corp.		<input type="checkbox"/> Individual																		
<input type="checkbox"/> Trust		<input type="checkbox"/> State																		
IRS Exemption Code _____		<input type="checkbox"/> Partnership																		
		<input type="checkbox"/> Corporation																		
		<input type="checkbox"/> County																		
		<input type="checkbox"/> Other _____																		
		<input checked="" type="checkbox"/> "Sub-S" Corp. _____																		
		<input type="checkbox"/> Limited Liability Co. _____																		
		<input type="checkbox"/> Trust																		
		<input type="checkbox"/> Other _____																		
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 384-6000</u> Please send copies of desk review and audit adjustments to address on this page		<table border="1"> <tr> <td rowspan="2"> Officer or Administrator of Provider </td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="5"> Paid Preparer </td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u></td> </tr> <tr> <td></td> <td><u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td colspan="2"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # <u>(217) 782-1630</u> </td> </tr> </table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u>		<u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # <u>(217) 782-1630</u>	
Officer or Administrator of Provider	(Signed) _____																			
	(Date) _____																			
Paid Preparer	(Type or Print Name) _____																			
	(Title) _____																			
	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>																			
	(Date) _____																			
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MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # <u>(217) 782-1630</u>																				

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>213</u>	Skilled (SNF)	<u>213</u>	<u>77,958</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>213</u>	TOTALS	<u>213</u>	<u>77,958</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>24,059</u>	<u>4,377</u>	<u>8,858</u>	<u>37,294</u>	8
9	SNF/PED					9
10	ICF	<u>18,512</u>	<u>4,360</u>	<u>388</u>	<u>23,260</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,571</u>	<u>8,737</u>	<u>9,246</u>	<u>60,554</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 77.68%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/20/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date New constructionNO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 213 and days of care provided 7,968Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lexington of Lake Zurich # 0039768 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	287,379	29,369	13,625	330,373		330,373		330,373			1
2	Food Purchase		259,876		259,876		259,876	(12,190)	247,686			2
3	Housekeeping	268,169	27,746		295,915		295,915	308	296,223			3
4	Laundry	60,229	17,183		77,412		77,412	(3,826)	73,586			4
5	Heat and Other Utilities			198,855	198,855		198,855	3,522	202,377			5
6	Maintenance	35,210		109,663	144,873		144,873	45,237	190,110			6
7	Other (specify):* Allocated Benefits							5,091	5,091			7
8	TOTAL General Services	650,987	334,174	322,143	1,307,304		1,307,304	38,142	1,345,446			8
	B. Health Care and Programs											
9	Medical Director			26,500	26,500		26,500		26,500			9
10	Nursing and Medical Records	3,119,654	182,892	452,208	3,754,754		3,754,754	59,468	3,814,222			10
10a	Therapy			668,866	668,866		668,866		668,866			10a
11	Activities	168,761	18,072	3,949	190,782		190,782		190,782			11
12	Social Services	65,723		4,091	69,814		69,814		69,814			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Allocated Benefits							7,191	7,191			15
16	TOTAL Health Care and Programs	3,354,138	200,964	1,155,614	4,710,716		4,710,716	66,659	4,777,375			16
	C. General Administration											
17	Administrative	86,569		998,135	1,084,704		1,084,704	(898,046)	186,658			17
18	Directors Fees											18
19	Professional Services			88,965	88,965		88,965	13,986	102,951			19
20	Dues, Fees, Subscriptions & Promotions			58,156	58,156		58,156	923	59,079			20
21	Clerical & General Office Expenses	212,465	43,709	22,918	279,092		279,092	281,835	560,927			21
22	Employee Benefits & Payroll Taxes			594,093	594,093		594,093	12,079	606,172			22
23	Inservice Training & Education			1,945	1,945		1,945		1,945			23
24	Travel and Seminar			1,704	1,704		1,704	3,841	5,545			24
25	Other Admin. Staff Transportation			1,084	1,084		1,084	9,881	10,965			25
26	Insurance-Prop.Liab.Malpractice			193,748	193,748		193,748	4,399	198,147			26
27	Other (specify):* Allocated Benefits							43,380	43,380			27
28	TOTAL General Administration	299,034	43,709	1,960,748	2,303,491		2,303,491	(527,722)	1,775,769			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,304,159	578,847	3,438,505	8,321,511		8,321,511	(422,921)	7,898,590			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington of Lake Zurich

#0039768

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			33,856	33,856		33,856	214,751	248,607			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,852	51,852		51,852	312,955	364,807			32
33	Real Estate Taxes							128,374	128,374			33
34	Rent-Facility & Grounds			1,326,805	1,326,805		1,326,805	(1,325,386)	1,419			34
35	Rent-Equipment & Vehicles			7,510	7,510		7,510	2,992	10,502			35
36	Other (specify):*											36
37	TOTAL Ownership			1,420,023	1,420,023		1,420,023	(666,314)	753,709			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		238,592		238,592		238,592		238,592			39
40	Barber and Beauty Shops			26,347	26,347		26,347		26,347			40
41	Coffee and Gift Shops			6,568	6,568		6,568		6,568			41
42	Provider Participation Fee			116,939	116,939		116,939		116,939			42
43	Other (specify):* Nonallowable Costs			106,223	106,223		106,223	(106,223)				43
44	TOTAL Special Cost Centers		238,592	256,077	494,669		494,669	(106,223)	388,446			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,304,159	817,439	5,114,605	10,236,203		10,236,203	(1,195,458)	9,040,745			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(111)	2		4
5 Telephone, TV & Radio in Resident Rooms	(3,291)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients	(3,826)	4		8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(10,203)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(917)	43		13
14 Non-Care Related Interest	(49,714)	32		14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	(3,051)	43		17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(240)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(58,449)	43		24
25 Fund Raising, Advertising and Promotional	(17,233)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See attached Schedule A	(28,294)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (175,329)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(1,020,129)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (1,020,129)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (1,195,458)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Lake Zurich

Provider #: 0039768

01/01/04 to 12/31/04

Schedule A

VI. Adjustment Detail

Line 29 - Other

Non-allowable expenses	Amount	Reference
Disallow nonallowable radiology	(11,655)	43
Disallow nonallowable laboratory	(4,956)	43
Penalties	(6,157)	43
Nonallowable collections	(3,302)	19
Cash over/under	(274)	43
Offset miscellaneous expense	(790)	21
Disallow out of period legal fees	(1,160)	19
	<u>(28,294)</u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Lake ZurichID# 0039768Report Period Beginning: 01/01/04Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/04

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	184,888	0	29,863	0	0	0	0	0	0	0	214,751	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(59,917)	372,511	0	361	0	0	0	0	0	0	0	312,955	32
33	Real Estate Taxes	0	126,805	0	1,569	0	0	0	0	0	0	0	128,374	33
34	Rent-Facility & Grounds	0	(1,326,805)	0	1,419	0	0	0	0	0	0	0	(1,325,386)	34
35	Rent-Equipment & Vehicles	0	0	0	2,992	0	0	0	0	0	0	0	2,992	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(59,917)	(642,601)	0	36,204	0	0	0	0	0	0	0	(666,314)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(83,181)	0	0	0	0	0	0	0	0	0	0	(83,181)	43
44	TOTAL Special Cost Centers	(83,181)	0	0	0	0	0	0	0	0	0	0	(83,181)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(147,035)	(642,199)	526,341	(904,271)	0	0	0	0	0	0	0	(1,167,164)	45

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

01/01/04

Ending:

12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas Discretionary Trust	33.33%			Lexington Health Care Systems of		
John Samatas Discretionary Trust	33.33%	See attached Schedule B		Lake Zurich Ltd Ptsp	Lake Zurich	Real estate ptsp.
Cynthia Thiem Discretionary Trust	33.34%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	19 Professional fees	\$	Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	\$ 217	\$ 217 1
2	V	21 Bank charges		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	75	75 2
3	V	21 Office Supplies		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	110	110 3
4	V	30 Depreciation		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	184,888	184,888 4
5	V	32 Interest expense		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	368,934	368,934 5
6	V	32 Amortization of mortgage cost		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	3,577	3,577 6
7	V	33 Property taxes		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	126,805	126,805 7
8	V	34 Rental expense	1,326,805	Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**		(1,326,805) 8
9	V						9
10	V						10
11	V	** The owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Lexington Health Care Systems of Lake Zurich Limited Partnership.					11
12	V						12
13	V						13
14	Total		\$ 1,326,805			\$ 684,606	\$ * (642,199) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Lake Zurich

Provider #

0039768

1/1/04 - 12/31/04

Schedule B

VII. Related Parties

Related Nursing Homes

Name of facility

City

Lexington Health Care Center of Lombard, Inc.

Lombard

Lexington Health Care Center of Bloomingdale, Inc.

Bloomingdale

Lexington Health Care Center of Chicago Ridge, Inc.

Chicago Ridge

Lexington Health Care Center of Elmhurst, Inc.

Elmhurst

Lexington Health Care Center of LaGrange, Inc.

LaGrange

Lexington Health Care Center of Schaumburg, Inc.

Schaumburg

Lexington Health Care Center of Streamwood, Inc.

Streamwood

Lexington Health Care Center of Wheeling, Inc.

Wheeling

Lexington Health Care Center of Orland Park, Inc.

Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Lake Zurich

0039768

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 Housekeeping supplies	\$	Housekeeping supplies	**	\$ 308	\$ 308 15
16	V	5 Utilities - gas & electric		Utilities - gas & electric	**	3,348	3,348 16
17	V	5 Utilities - water & sewer		Utilities - water & sewer	**	89	89 17
18	V	5 Utilities - maintenance office		Utilities - maintenance office	**	85	85 18
19	V	6 Management allocation - salaries		Management allocation - salaries	**	42,098	42,098 19
20	V	6 Repairs & maintenance		Repairs & maintenance	**	3,139	3,139 20
21	V	7 Management allocation - employee benefits		Management allocation - employee benefits	**	5,091	5,091 21
22	V	10 Management allocation - salaries		Management allocation - salaries	**	59,468	59,468 22
23	V	15 Management allocation - employee benefits		Management allocation - employee benefits	**	7,191	7,191 23
24	V	17 Management allocation - salaries		Management allocation - salaries	**	100,089	100,089 24
25	V	19 Computer consultant & supplies		Computer consultant & supplies	**	11,205	11,205 25
26	V	19 Professional fees		Professional fees	**	7,026	7,026 26
27	V	20 Dues & subscriptions		Dues & subscriptions	**	828	828 27
28	V	20 Licenses, permits & inspections		Licenses, permits & inspections	**	22	22 28
29	V	20 Advertising - help wanted		Advertising - help wanted	**	73	73 29
30	V	21 Management allocation - salaries		Management allocation - salaries	**	258,644	258,644 30
31	V	21 Bank charges		Bank charges	**	2,057	2,057 31
32	V	21 Office supplies & printing		Office supplies & printing	**	8,741	8,741 32
33	V	21 Postage		Postage	**	3,581	3,581 33
34	V	21 Telephone		Telephone	**	9,417	9,417 34
35	V	24 Travel & seminar		Travel & seminar	**	3,841	3,841 35
36	V						36
37	V						37
38	V	** Certain owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Royal Management Corp.					38
39	Total		\$			\$ 526,341	\$ * 526,341 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

0039768

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	25 Auto expense	\$	Royal Management Corp.	**	\$ 9,881	\$ 9,881
16	V	26 Insurance general		Royal Management Corp.	**	4,399	4,399
17	V	27 Management allocation - employee benefits		Royal Management Corp.	**	43,380	43,380
18	V	30 Depreciation - vehicles		Royal Management Corp.	**	3,205	3,205
19	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	6,948	6,948
20	V	30 Depreciation - equipment		Royal Management Corp.	**	19,710	19,710
21	V	32 Interest		Royal Management Corp.	**	361	361
22	V	33 Property taxes		Royal Management Corp.	**	1,569	1,569
23	V	34 Rent expense		Royal Management Corp.	**	1,419	1,419
24	V	35 Equipment rental		Royal Management Corp.	**	2,992	2,992
25	V	17 Management fees	998,135	Royal Management Corp.	**		(998,135)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 998,135			\$ 93,864	\$ * (904,271)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich # 0039768 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	4	8%	Salary	\$ 33,306	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33%	See Schedule C	3	6%	Salary	23,790	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	3	6%	Salary	23,790	L17, C7	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	1	3%	Salary	5,795	L17, C7	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	5	10%	Salary	13,408	L17, C7	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 100,089		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Lake Zurich
Provider # 0039768
1/1/04 - 12/31/04

Schedule C

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives
and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

<u>Name of facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>George Samatas</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Bloomingdale, Inc.	19,211	26,895	19,211	4,679	10,827	80,823
Lexington Health Care Center of Chicago Ridge, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Elmhurst, Inc.	16,754	23,455	16,754	4,081	9,442	70,486
Lexington Health Care Center of LaGrange, Inc.	12,174	17,044	12,174	2,965	6,861	51,218
Lexington Health Care Center of Lombard, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Orland Park, Inc.	30,154	42,219	30,154	7,346	16,995	126,868
Lexington Health Care Center of Schaumburg, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Streamwood, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Wheeling, Inc.	24,684	34,557	24,684	6,012	13,912	103,849
Total	203,053	284,274	203,053	49,459	114,437	854,276

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	743,346	10	\$ 2,938	\$	77,958	308	1
2	5	Utilities - gas & electric	Bed Days	743,346	10	31,920		77,958	3,348	2
3	5	Utilities - water & sewer	Bed Days	743,346	10	846		77,958	89	3
4	5	Utilities - maintenance office	Bed Days	743,346	10	808		77,958	85	4
5	6	Management allocation - salaries	Bed Days	743,346	10	401,410	401,410	77,958	42,098	5
6	6	Repairs & maintenance	Bed Days	743,346	10	29,930		77,958	3,139	6
7	7	Management allocation - employee	Bed Days	743,346	10	48,540		77,958	5,091	7
8	10	Management allocation - salaries	Bed Days	743,346	10	567,037	567,037	77,958	59,468	8
9	15	Management allocation - employee	Bed Days	743,346	10	68,569		77,958	7,191	9
10	17	Management allocation - salaries	Bed Days	743,346	10	954,365	954,365	77,958	100,089	10
11	19	Computer consultant & supplies	Bed Days	743,346	10	106,838		77,958	11,205	11
12	19	Professional fees	Bed Days	743,346	10	66,993		77,958	7,026	12
13	20	Dues & subscriptions	Bed Days	743,346	10	7,893		77,958	828	13
14	20	Licenses, permits & inspections	Bed Days	743,346	10	212		77,958	22	14
15	20	Advertising - help wanted	Bed Days	743,346	10	698		77,958	73	15
16	21	Management allocation - salaries	Bed Days	743,346	10	2,466,223	2,466,223	77,958	258,644	16
17	21	Bank charges	Bed Days	743,346	10	19,618		77,958	2,057	17
18	21	Office supplies & printing	Bed Days	743,346	10	83,348		77,958	8,741	18
19	21	Postage	Bed Days	743,346	10	34,142		77,958	3,581	19
20	21	Telephone	Bed Days	743,346	10	89,797		77,958	9,417	20
21	24	Travel & seminar	Bed Days	743,346	10	36,624		77,958	3,841	21
22										22
23										23
24										24
25	TOTALS					\$ 5,018,749	\$ 4,389,035		\$ 526,341	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	10	\$ 94,217	\$	77,958	\$ 9,881	1
2	26	Insurance general	Bed Days	10	41,943		77,958	4,399	2
3	27	Management allocation - employee	Bed Days	10	413,634		77,958	43,380	3
4	30	Depreciation - vehicles	Bed Days	10	30,557		77,958	3,205	4
5	30	Depreciation - leasehold improv.	Bed Days	10	66,255		77,958	6,948	5
6	30	Depreciation - equipment	Bed Days	10	187,937		77,958	19,710	6
7	32	Interest	Bed Days	10	3,446		77,958	361	7
8	33	Property taxes	Bed Days	10	14,963		77,958	1,569	8
9	34	Rent expense	Bed Days	10	13,526		77,958	1,419	9
10	35	Equipment rental	Bed Days	10	28,527		77,958	2,992	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 895,005	\$		\$ 93,864	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

01/01/04

Ending:

12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Lexington Financial						\$		\$			\$		1					
2	Services II, L.L.C.	X		Mortgage	\$49,256.00	12/29/98		6,478,000		5,363,208	12/29/08	0.0675		368,934	2				
3															3				
4															4				
5															5				
	Working Capital																		
6	Shareholders	X		Working Capital	None	Varies		270,033		2,155,782	Demand	0.0300		49,714	6				
7	LaSalle Bank, N.A.		X	Line of Credit	Varies	12/01/02		750,000		200,000	5/31/05	Prime		2,138	7				
8															8				
9	TOTAL Facility Related				\$49,256.00		\$	7,498,033	\$	7,718,990				\$	420,786	9			
	B. Non-Facility Related*																		
10									Amortization of loan costs						3,577	10			
11									Interest income offset						(10,203)	11			
12									Allocated from management company					361	12				
13									Nonallowable shareholder interest					(49,714)	13				
14	TOTAL Non-Facility Related						\$		\$				\$	(55,979)	14				
15	TOTALS (line 9+line14)						\$	7,498,033	\$	7,718,990				\$	364,807	15			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Lexington of Lake Zurich**# **0039768** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2003 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	141,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		Allocated from management company	\$	1,569	
		2003	\$	132,805	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(6,626)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	135,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	128,374	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	112,784	8	
		2000	120,166	9	
		2001	141,884	10	
		2002	136,724	11	
		2003	132,805	12	
2004 assessment	2,091,552				
Equalization Factor:	1.0000				
Tax Rate:	0.06502				
Estimated 2004 taxes:	135,993				
Use:	135,000				

FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Lake Zurich COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0039768

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-28-100-020</u>	<u>Nursing Facility</u>	\$ <u>125,906.00</u>	\$ <u>125,906.00</u>
2. <u>14-29-200-033</u>	<u>Nursing Facility</u>	\$ <u>6,899.00</u>	\$ <u>6,899.00</u>
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
4. <u>05-01-202-019</u>		\$ <u>187,600.00</u>	\$ <u>1,569.00</u>
5. _____		\$ _____	\$ _____
6. _____		\$ _____	\$ _____
7. _____		\$ _____	\$ _____
8. _____		\$ _____	\$ _____
9. _____		\$ _____	\$ _____
10. _____		\$ _____	\$ _____
TOTALS		\$ <u>320,405.00</u>	\$ <u>134,374.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,901
 B. General Construction Type:
 Exterior Brick
 Frame Steel
 Number of Stories 3

C. Does the Operating Entity?
 (a) Own the Facility
 (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	250,344	1990	\$ 495,000	1
2	Allocated from management company			16,025	2
3	TOTALS	250,344		\$ 511,025	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

0039768

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	203	1994	1994	\$ 6,418,908	\$	40	\$ 160,473	\$ 160,473	\$ 1,658,219
5	10	2003	2003						
6									
7									
8									
Improvement Type**									
9	Land Improvements	1994	1994	10,701		10	535	535	10,701
10	Land Improvements	1994	1994	13,330	666	10	666		13,330
11	Leasehold Improvements	1994	1994	4,737	316	15	316		3,316
12	Leasehold Improvements	1995	1995	4,005	267	15	267		2,537
13	Land Improvements	1995	1995	3,221		10	322	322	3,060
14	Building Improvements	1995	1995	3,019		40	75	75	718
15	Building Improvements	1995	1995	64,500	1,654	39	1,654		16,058
16	Patio	1996	1996	1,168	78	15	78		662
17	Compressor	1996	1996	5,145	514	10	514		4,372
18	Road sidewalk	1997	1997	18,094		20	905	905	6,785
19	Foundation/Sprinkler	1997	1997	2,068	59	35	59		443
20	Flagpoles	1997	1997	1,573	105	15	105		787
21	Basement rehab	1998	1998	12,867	1,287	10	1,287		8,364
22	MDS Telnet wiring	1998	1998	3,365	337	10	337		2,188
23	Flag Pole	1998	1998	787	52	15	52		340
24	Resurface/restripe parking lot	1998	1998	4,976	498	10	498		3,236
25	Transfer 10 beds from shelter care	1998	1998	2,259	56	40	56		347
26	1st floor lobby tile	1999	1999	12,153	1,215	10	1,215		6,685
27	Parking lot repair	2000	2000	3,740	374	10	374		1,683
28	Roof repair	2000	2000	10,770	1,077	10	1,077		4,846
29	Automatic door	2000	2000	1,300	130	10	130		585
30	Kitchen rehab	2000	2000	16,887	1,689	10	1,689		7,600
31	Compressor	2001	2001	4,350	435	10	435		1,522
32	Boiler vent	2001	2001	3,228	323	10	323		1,130
33	Fire pump	2001	2001	1,766	177	10	177		619
34	Kitchen rehab	2001	2001	721	72	10	72		252
35	Elevator infrared curtains	2001	2001	4,500	450	10	450		1,575
36	Therapy room rehab - lower level	2004	2004	64,473	1,075	20	1,075		1,075

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Elevator Upgrade	2004	\$ 3,486	\$ 15	20	\$ 15	\$	\$ 15	37
38	HVAC Compressor	2004	11,845	148	20	148		148	38
39									39
40	Land improvements - management company	2002	25,257		15	1,707	1,707	4,911	40
41	Building - management company	2002	196,500		40	5,089	5,089	14,328	41
42	HVAC, electrical, security system - management company	2003	1,948		30	136	136	185	42
43	Key card system - management company	2004	306		20	16	16	16	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,937,953	\$ 13,069		\$ 182,327	\$ 169,258	\$ 1,782,638	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Lake Zurich

0039768

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 139,282	\$ 15,463	\$ 16,478	\$ 1,015	3-10 yrs	\$ 71,029	71
72	Current Year Purchases	86,216	3,102	3,102		3-10 yrs	3,102	72
73	Fully Depreciated Assets	486,785	2,220	23,785	21,565		486,785	73
74	Allocated from management company	188,483		19,710	19,710		78,722	74
75	TOTALS	\$ 900,766	\$ 20,785	\$ 63,075	\$ 42,290		\$ 639,638	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from management company			39,445		3,205	3,205		27,104	79
80	TOTALS			\$ 39,445	\$	\$ 3,205	\$ 3,205		\$ 27,104	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,389,189	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,854	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 248,607	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 214,753	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,449,380	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Therapy Room - First Floor	\$ 48,297	92
93	Boilers	2,635	93
94	Lobby lounge	42,871	94
95		\$ 93,803	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from management company				1,419			6
7	TOTAL				\$ 1,419			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 10,502 Description: Copier: \$7,060; Fax: \$270; Mailing machine: \$180; Allocation from management company: \$2,992
(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2005 \$ _____
13. _____/2006 \$ _____
14. _____/2007 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	3,489	\$ 219,900	\$	3,489	\$ 219,900	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,919	61,390		1,919	61,390	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		7,131	387,576		7,131	387,576	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				238,592		238,592	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	12,539	\$ 668,866	\$ 238,592	12,539	\$ 907,458	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Lexington of Lake Zurich

0039768

Report Period Beginning: 01/01/04

Ending:

12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 188,344	\$ 212,999	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 537,000)	1,971,442	1,971,442	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	502	502	6
7	Other Prepaid Expenses	29,478	29,478	7
8	Accounts Receivable (owners or related parties)	1,303	1,303	8
9	Other(specify): Escrows		39,785	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,191,069	\$ 2,255,509	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,652	8,652	12
13	Land		511,025	13
14	Buildings, at Historical Cost		6,418,908	14
15	Leasehold Improvements, at Historical Cost	260,000	519,045	15
16	Equipment, at Historical Cost	270,854	940,211	16
17	Accumulated Depreciation (book methods)	(205,630)	(2,449,380)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attached Schedule E	93,803	143,889	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 427,679	\$ 6,092,350	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,618,748	\$ 8,347,859	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 468,577	\$ 468,577	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1	1	28
29	Short-Term Notes Payable	2,355,782	2,355,782	29
30	Accrued Salaries Payable	216,325	216,325	30
31	Accrued Taxes Payable (excluding real estate taxes)	99,879	99,879	31
32	Accrued Real Estate Taxes(Sch.IX-B)		135,000	32
33	Accrued Interest Payable		30,168	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	1,135,408	250,208	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,275,972	\$ 3,555,940	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,363,208	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,363,208	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,275,972	\$ 8,919,148	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,657,224)	\$ (571,289)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,618,748	\$ 8,347,859	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington of Lake Zurich
Provider #0039768
1/1/04 - 12/31/04

Schedule E

XV. Balance Sheet

B. Long Term Assets

23. Other Long Term Assets

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Construction in progress	93,803	93,803
Unamortized mortgage costs	-	50,086
Total line 23	<u>93,803</u>	<u>143,889</u>

C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Rent	885,200	-
Accrued Bond Withholding	357	357
Accrued management fees	175,593	175,593
Accrued 401 (k) contribution	6,429	6,429
Accrued Wage Assignment	(266)	(266)
Other accrued expenses	49,026	49,026
Due to related parties	19,069	19,069
Total line 36	<u>1,135,408</u>	<u>250,208</u>

XVII. Income Statement

E. Other Revenue

28. Other Revenue

<u>Description</u>	<u>Amount</u>
Investment Income in Lexington Financial Services II, LLC	86
Vending machine commission	666
Total line 28	<u>752</u>

See Accountants' Compilation Report

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (782,858)	1
2	Restatements (describe):		2
3	Post closing entries	(177,295)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (960,153)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(697,071)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (697,071)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,657,224)	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,537,709	1
2	Discounts and Allowances for all Levels	(747,869)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,789,840	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,180,607	6
7	Oxygen	217	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,180,824	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	7,417	12
13	Barber and Beauty Care	33,707	13
14	Non-Patient Meals	111	14
15	Telephone, Television and Radio	3	15
16	Rental of Facility Space		16
17	Sale of Drugs	417,402	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,875	19
20	Radiology and X-Ray	11,447	20
21	Other Medical Services	60,725	21
22	Laundry	3,826	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 557,513	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10,203	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,203	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	752	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 752	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,539,132	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,307,304	31
32	Health Care	4,710,716	32
33	General Administration	2,303,491	33
B. Capital Expense			
34	Ownership	1,420,023	34
C. Ancillary Expense			
35	Special Cost Centers	377,730	35
36	Provider Participation Fee	116,939	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,236,203	40
41	Income before Income Taxes (line 30 minus line 40)**	(697,071)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (697,071)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity files a cash basis tax return.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Lexington of Lake Zurich**# **0039768**Report Period Beginning: **01/01/04**Ending: **12/31/04**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,170	2,225	\$ 96,109	\$ 43.20	1
2	Assistant Director of Nursing	3,274	3,427	104,856	30.60	2
3	Registered Nurses	40,778	43,532	1,313,983	30.18	3
4	Licensed Practical Nurses	9,167	9,871	241,763	24.49	4
5	Nurse Aides & Orderlies	100,467	105,473	1,269,557	12.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,362	8,735	93,386	10.69	8
9	Activity Director	1,753	1,826	27,589	15.11	9
10	Activity Assistants	14,666	15,252	141,172	9.26	10
11	Social Service Workers	3,454	3,527	65,723	18.63	11
12	Dietician	2,046	2,166	31,496	14.54	12
13	Food Service Supervisor	1,115	1,297	17,760	13.69	13
14	Head Cook	2,086	2,166	24,461	11.29	14
15	Cook Helpers/Assistants	12,823	13,659	106,295	7.78	15
16	Dishwashers	16,664	17,480	107,367	6.14	16
17	Maintenance Workers	2,006	2,256	35,210	15.61	17
18	Housekeepers	38,543	40,916	268,169	6.55	18
19	Laundry	9,519	9,910	60,229	6.08	19
20	Administrator	1,987	2,107	86,569	41.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,999	14,185	212,465	14.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	283,879	300,010	\$ 4,304,159 *	\$ 14.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	282	\$ 13,625	L1, C3	35
36	Medical Director	12	26,500	L9, C3	36
37	Medical Records Consultant	26	1,427	L10, C3	37
38	Nurse Consultant	32	2,935	L10, C3	38
39	Pharmacist Consultant	12	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	82	3,949	L11, C3	44
45	Social Service Consultant	125	4,091	L12, C3	45
46	Other(specify) <u>Rehabcare</u>	3	92	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	574	\$ 53,819		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	7,632	\$ 228,973	L10, C3	50
51	Licensed Practical Nurses	6,171	154,263	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	13,803	\$ 383,236		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Lexington of Lake Zurich**

XIX. SUPPORT SCHEDULES

STATE OF ILLINOIS

0039768

Report Period Beginning: **01/01/04**

Page 21

Ending: **12/31/04**

<p>A. Administrative Salaries</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 10%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 10%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Steve Klekamp</td> <td>Administrator</td> <td>0.00%</td> <td style="text-align: right;">\$ 49,465</td> </tr> <tr> <td>Debbie Randon</td> <td>Administrator</td> <td>0.00%</td> <td style="text-align: right;">37,104</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 86,569</td> </tr> </tbody> </table> <p>B. Administrative - Other</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Description</th> <th style="width: 30%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Management fees (eliminated in column 7)</td> <td style="text-align: right;">\$ 998,135</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</td> <td style="text-align: right;">\$ 998,135</td> </tr> </tbody> </table> <p>C. Professional Services</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Vendor/Payee</th> <th style="width: 10%;">Type</th> <th style="width: 60%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Altschuler, Melvoin & Glasser LLP</td> <td>Accounting</td> <td style="text-align: right;">\$ 15,022</td> </tr> <tr> <td>American Express Tax & Bus. 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* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Lake Zurich, Inc.
 Provider # 0039768
 1/1/04 - 12/31/04

Schedule F

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Mccorkle Court Reporters	Legal	464
MI TI Record Service	Legal	98
Scott & Krause	Legal	228
Avail Corporation	Accounting	142
Advanced Answers on Demand	Computer Services	2,652
AdminaStar	Computer Services	396
Gigatrend	Computer Services	195
eHealth Solutions	Computer Services	3,600
Information Controls Inc.	Computer Services	1,156
Lanac	Computer Services	792
National Datacare	Computer Services	265
Covad Communications	Computer Services	1,244
Garbowski & Green	Collections	3,301
		<u>14,533</u>

Total, Agrees to Schedule V, Line 19, Column 3

88,965

Allocated from management co.

Altschuler, Melvoin & Glasser LLP	Accounting	506
American Express Tax & Business Services	Accounting	319
Account Temps	Accounting	868
Avail Corporation	Accounting	25
Gilson, Labus and Silverman	Accounting	263
James Samatas	Legal	37
Doris Fischer	Medicaid Billing Consultant	2,231
Sachnoff and Weaver	Legal	1,040
ING / Pension Administrators	401 (k) Administration	912
Personnel Planners	U/C Consulting	12
Susan Parker, LCSW	DNR Consulting	11
Eric Haider	Consultant	28
Gene Whitehorn	Medicaid Billing Consultant	773
Various	Computer consulting	11,205

Allocated from building partnership

James Samatas	Legal	217
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Nonallowable legal fees

Katten, Muchin, Zavis and Rosenman	Legal-out of period	(932)
Scott & Krause	Legal-out of period	(228)
Grabowski & Green	Legal-collection fees	(3,301)

Reclassifications

-

Total, Agrees to Schedule V, Line 19, Column 8

102,951

See accountants' compilation report.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 6 7 8 9 10 11 12 13 Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2							N/A						
3													
4													
5													
6													
7													
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9													
10													
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15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

STATE OF ILLINOIS

0039768

Report Period Beginning:

01/01/04

Ending:

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12/31/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,158 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES N/A NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 116,939
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 12,079 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 111
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	287,379	29,369	13,625	330,373	0	330,373	0	330,373
2. Food Purchase	0	259,876	0	259,876	0	259,876	-12,190	247,686
3. Housekeeping	268,169	27,746	0	295,915	0	295,915	308	296,223
4. Laundry	60,229	17,183	0	77,412	0	77,412	-3,826	73,586
5. Heat and Other Utilities	0	0	198,855	198,855	0	198,855	3,522	202,377
6. Maintenance	35,210	0	109,663	144,873	0	144,873	45,237	190,110
7. Other (specify)*	0	0	0	0	0	0	5,091	5,091
8. Total General Services	650,987	334,174	322,143	1,307,304	0	1,307,304	38,142	1,345,446
9. Medical Director	0	0	26,500	26,500	0	26,500	0	26,500
10. Nursing & Medical Records	3,119,654	182,892	452,208	3,754,754	0	3,754,754	59,468	3,814,222
10a. Therapy	0	0	668,866	668,866	0	668,866	0	668,866
11. Activities	168,761	18,072	3,949	190,782	0	190,782	0	190,782
12. Social Services	65,723	0	4,091	69,814	0	69,814	0	69,814
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	7,191	7,191
16. Total Health Care & Programs	3,354,138	200,964	1,155,614	4,710,716	0	4,710,716	66,659	4,777,375
17. Administrative	86,569	0	998,135	1,084,704	0	1,084,704	-898,046	186,658
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	88,965	88,965	0	88,965	13,986	102,951
20. Fees, Subscriptions & Promotion	0	0	58,156	58,156	0	58,156	923	59,079
21. Clerical & General Office	212,465	43,709	22,918	279,092	0	279,092	281,835	560,927
22. Employee Benefits & Payroll	0	0	594,093	594,093	0	594,093	12,079	606,172
23. Inservice Training & Education	0	0	1,945	1,945	0	1,945	0	1,945
24. Travel and Seminar	0	0	1,704	1,704	0	1,704	3,841	5,545
25. Other Admin. Staff Trans	0	0	1,084	1,084	0	1,084	9,881	10,965
26. Insurance-Prop.Liab.Malpractice	0	0	193,748	193,748	0	193,748	4,399	198,147
27. Other (specify)*	0	0	0	0	0	0	43,380	43,380
28. Total General Adminis	299,034	43,709	1,960,748	2,303,491	0	2,303,491	-527,722	1,775,769
29. Total General Administrative	4,304,159	578,847	3,438,505	8,321,511	0	8,321,511	-422,921	7,898,590
30. Depreciation	0	0	33,856	33,856	0	33,856	214,751	248,607
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	51,852	51,852	0	51,852	312,955	364,807
33. Real Estate	0	0	0	0	0	0	128,374	128,374
34. Rent - Facility & Grounds	0	0	1,326,805	1,326,805	0	1,326,805	-1,325,386	1,419
35. Rent - Equipment & Vehicles	0	0	7,510	7,510	0	7,510	2,992	10,502
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,420,023	1,420,023	0	1,420,023	-666,314	753,709
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	238,592	0	238,592	0	238,592	0	238,592
40. Barber and Beauty Shop	0	0	26,347	26,347	0	26,347	0	26,347
41. Coffee and Gift Shops	0	0	6,568	6,568	0	6,568	0	6,568
42. Provider Participation	0	0	116,939	116,939	0	116,939	0	116,939
43. Other (specify):*	0	0	106,223	106,223	0	106,223	-106,223	0
44. Total Special Cost Ce	0	238,592	256,077	494,669	0	494,669	-106,223	388,446
45. Grand Total	4,304,159	817,439	5,114,605	10,236,203	0	10,236,203	-1,195,458	9,040,745

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	188,344	212,999
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,971,442	1,971,442
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	502	502
7. Other Prepaid Expenses	29,478	29,478
8. Accounts Receivable-Owner/Related Party	1,303	1,303
9. Other (specify):	0	39,785
10. Total current assets	2,191,069	2,255,509
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	8,652	8,652
13. Land	0	511,025
14. Buildings, at Historical Cost	0	6,418,908
15. Leasehold Improvements, Historical Cost	260,000	519,045
16. Equipment, at Historical Cost	270,854	940,211
17. Accumulated Depreciation (book methods)	-205,630	-2,449,380
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	93,803	143,889
24. Total Long-Term Assets	427,679	6,092,350
25. Total Assets	2,618,748	8,347,859
CURRENT LIABILITIES		
26. Accounts Payable	468,577	468,577
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	1	1
29. Short-Term Notes Payable	2,355,782	2,355,782
30. Accrued Salaries Payable	216,325	216,325
31. Accrued Taxes Payable	99,879	99,879
32. Accrued Real Estate Taxes	0	135,000
33. Accrued Interest Payable	0	30,168
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	1,135,408	250,208
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	4,275,972	3,555,940
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	5,363,208
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	5,363,208
46. Total Liabilities	4,275,972	8,919,148
47. Total Equity	-1,657,224	-571,289
48. Total Liabilities and Equity	2,618,748	8,347,859

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	8,537,709
2. Discounts and Allowances for all Levels	-747,869
Subtotal - Inpatient Care	7,789,840
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,180,607
7. Oxygen	217
Subtotal - Ancillary Revenue	1,180,824
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	7,417
13. Barber and Beauty Care	33,707
14. Non-Patient Meals	111
15. Telephone, Television, and Radio	3
16. Rental of Facility Space	0
17. Sale of Drugs	417,402
18. Sale of Supplies to Non-Patients	0
19. Laboratory	22,875
20. Radiology and X-Ray	11,447
21. Other Medical Services	60,725
22. Laundry	3,826
Subtotal - Other Operating Revenue	557,513
24. Contributions	0
25. Interest and Other Investments Income	10,203
Subtotal - Non-Operating Revenue	10,203
27. Other Revenue (specify):	0
28. Other Revenue (specify):	752
Subtotal - Other Revenue	752
30. Total Revenue	9,539,132
31. General Services	1,307,304
32. Health Care	4,710,716
33. General Administration	2,303,491
34. Ownership	1,420,023
35. Special Cost Centers	377,730
35. Provider Participation Fee	116,939
37. Other	0
40. Total Expenses	10,236,203
41. Income Before Income Taxes	-697,071
42. Income Taxes	0
43. Net Income or Loss for the Year	-697,071

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